		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012955

Facility Name: PROPHETS RIVERVIEW

Address: 310 MOSHER DRIVE (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: (815)537-5175 **Fax #** (815)537-2628

IDPA ID Number: 45-0228055

Date of Initial License for Current Owners:

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALETA CARLSON **Telephone Number:** (605)362-3873

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,649	13,302	1,230	24,181	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,649	13,302	1,230	24,181	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.64%

D. How many bed-hold days during this year were paid by Public Aid?
95 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy, Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started / /

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,230

Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	174,546	7,291	4,179	186,016		186,016		186,016			1
2	Food Purchase		119,702		119,702		119,702	(7,826)	111,876			2
3	Housekeeping	58,451	12,639		71,090		71,090		71,090			3
4	Laundry	52,426	16,237		68,663		68,663		68,663			4
5	Heat and Other Utilities			69,806	69,806		69,806	(4,613)	65,193			5
6	Maintenance	53,098	8,959	30,824	92,881		92,881	155	93,036			6
7	Other (specify):*			932	932		932	(424)	508			7
8	**TOTAL General Services**	338,521	164,828	105,741	609,090		609,090	(12,708)	596,382			8
	B. Health Care and Programs											
9	Medical Director	911,952	73,491	10,329	995,772		995,772		995,772			9
10	Nursing and Medical Records	31,435	1,005	36,308	68,748	(9,163)	59,585	(25,428)	34,157			10
10a	Therapy	68,895	3,034	7,511	79,440		79,440	(16,401)	63,039			10a
11	Activities	27,946	265	1,934	30,145		30,145		30,145			11
12	Social Services											12
13	Nurse Aide Training					9,163	9,163		9,163			13
14	Program Transportation			749	749		749		749			14
15	Other (specify):*	33,448			33,448		33,448		33,448			15
16	**TOTAL Health Care and Programs**	1,073,676	77,795	56,831	1,208,302		1,208,302	(41,829)	1,166,473			16
	C. General Administration											
17	Administrative	47,862		102,410	150,272		150,272	32,338	182,610			17
18	Directors Fees											18
19	Professional Services			2,850	2,850		2,850		2,850			19
20	Dues, Fees, Subscriptions & Promotions			7,681	7,681		7,681	(3,088)	4,593			20
21	Clerical & General Office Expenses	80,768	7,313	30,886	118,967		118,967	(6,862)	112,105			21
22	Employee Benefits & Payroll Taxes			261,973	261,973		261,973	8,395	270,368			22
23	Inservice Training & Education			13,945	13,945		13,945		13,945			23
24	Travel and Seminar			3,032	3,032		3,032		3,032			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			17,077	17,077		17,077	5,509	22,586			26
27	Other (specify):* Res Dev			177	177		177	(48)	129			27
28	**TOTAL General Administration**	128,630	7,313	440,031	575,974		575,974	36,244	612,218			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,540,827	249,936	602,603	2,393,366		2,393,366	(18,293)	2,375,073			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROPHETS RIVERVIEW #0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			134,972	134,972		134,972		134,972			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			480	480		480	(480)				34
35	Rent-Equipment & Vehicles			3,668	3,668		3,668		3,668			35
36	Other (specify):*											36
37	**TOTAL Ownership**			139,120	139,120		139,120	(480)	138,640			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,581	2,581		2,581	(2,581)				39
40	Barber and Beauty Shops		164	3,030	3,194		3,194	(3,194)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		164	43,936	44,100		44,100	(5,775)	38,325			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,540,827	250,100	785,659	2,576,586		2,576,586	(24,548)	2,552,038			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,826)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,613)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,088)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(55,263)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	**$ (70,790)**		**$**	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	46,242		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	**$ 46,242**		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	**$ (24,548)**		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PROPHETS RIVERVIEW

ID# 0012955

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Uniform Inc	$ (3,034)	21	1
2	Administration	(340)	21	2
3	Wanderguard	(3,353)	21	3
4	Postage	(5)	21	4
5	Resident Supplies	(424)	7	5
6	Telephone	(1)	21	6
7	Med Supplies - Part B	(4,947)	10	7
8	Deferred Maint Exp - 2001	155	6	8
9	Prescr Drugs - Reimb	(20,481)	10	9
10	Beauty & Barbar Expense	(3,194)	40	10
11	Misc Fdraisers Exp	(129)	21	11
12	Bldg Rent - Therapy	(480)	34	12
13	Therapy Offset - PT, OT, ST	(16,401)	10A	13
14	Purch Svc - Laboratory	(1,356)	39	14
15	Purch Svc - Radiology	(1,185)	39	15
16	Lab Fees	(40)	39	16
17	Resourse Development - Public Relations	(48)	27-3	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(55,263)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,826)	0	0	0	0	0	0	0	0	0	0	(7,826)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,613)	0	0	0	0	0	0	0	0	0	0	(4,613)	5
6	Maintenance	155	0	0	0	0	0	0	0	0	0	0	155	6
7	Other (specify):*	(424)	0	0	0	0	0	0	0	0	0	0	(424)	7
8	**TOTAL General Services**	(12,708)	0	0	0	0	0	0	0	0	0	0	(12,708)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(25,428)	0	0	0	0	0	0	0	0	0	0	(25,428)	10
10a	Therapy	(16,401)	0	0	0	0	0	0	0	0	0	0	(16,401)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(41,829)	0	0	0	0	0	0	0	0	0	0	(41,829)	16
	C. General Administration													
17	Administrative	0	32,338	0	0	0	0	0	0	0	0	0	32,338	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,088)	0	0	0	0	0	0	0	0	0	0	(3,088)	20
21	Clerical & General Office Expenses	(6,862)	0	0	0	0	0	0	0	0	0	0	(6,862)	21
22	Employee Benefits & Payroll Taxes	0	8,395	0	0	0	0	0	0	0	0	0	8,395	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	5,509	0	0	0	0	0	0	0	0	0	5,509	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,950)	46,242	0	0	0	0	0	0	0	0	0	36,292	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(64,487)	46,242	0	0	0	0	0	0	0	0	0	(18,245)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(480)	0	0	0	0	0	0	0	0	0	0	(480)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(480)	0	0	0	0	0	0	0	0	0	0	(480)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(2,581)	0	0	0	0	0	0	0	0	0	0	(2,581)	39
40	Barber and Beauty Shops	(3,194)	0	0	0	0	0	0	0	0	0	0	(3,194)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(5,775)	0	0	0	0	0	0	0	0	0	0	(5,775)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(70,742)	46,242	0	0	0	0	0	0	0	0	0	(24,500)	45

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Ev Lutheran	100%					
Good Samaritan Society						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Admin/Acctg	$ 102,410	The Ev Lutheran Good Samaritan Society		$ 134,748	$ 32,338	1
2	V									2
3	V		22	Unemployment	6,221			6,278	57	3
4	V									4
5	V		22	Workers Comp	27,996			36,334	8,338	5
6	V									6
7	V		26	Insurance	17,076			22,585	5,509	7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 153,703			$ 199,945	$ * 46,242	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: The EV Lutheran Good Samaritan Society
Street Address: 4800 W 57th St PO Box 5038
City / State / Zip Code: Sioux Falls, SD 57117-5038
Phone Number: (605)362-3100
Fax Number: (605)362-3265

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See Report on Allowable Central Office Expenses for the				$	$		$	1
2		Year ended 12/31/01 submitted under separate cover								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NOT APPLICABLE						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	1,751	8
	1997		9
	1998		10
	1999		11
	2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROPHETS RIVERVIEW COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0012955

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,259 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

APARTMENTS - 4

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1966	$ 15,000	1
2					2
3	TOTALS			$ 15,000	3

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1967 #	1967 #	347,119	8,678	40	$ 8,678	$	$ 297,219	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building										9
10			1973	1973	669	17	40	17		471	10
11			1974	1974	483	12	40	12		332	11
12			1975	1975	31,653	791	varies	791		21,367	12
13			1977	1977	4,675	-	20	-		4,675	13
14			1979	1979	7,265	-	20	-		7,265	14
15			1980	1980	6,108	109	varies	109		4,153	15
16			1981	1981	58,599	1,460	varies	1,460		30,850	16
17			1982	1982	8,456	396	varies	396		8,186	17
18			1983	1983	14,821	741	varies	741		13,771	18
19			1984	1984	8,772	439	varies	439		7,584	19
20			1985	1985	46,344	699	varies	699		44,110	20
21			1986	1986	7,033	15	varies	15		6,963	21
22			1987	1987	78,081	3,616	varies	3,616		56,732	22
23			1988	1988	48,915	1,128	varies	1,128		39,486	23
24			1989	1989	102,492	448	varies	448		101,309	24
25			1990	1990	924,681	41,758	varies	41,758		595,548	25
26			1991	1991	5,729	261	varies	261		4,933	26
27			1992	1992	24,954	1,942	varies	1,942		20,865	27
28			1993	1993	13,504	402	varies	402		9,901	28
29			1994	1994	45,574	1,000	varies	1,000		36,362	29
30			1995	1995	31,371	1,133	varies	1,133		22,590	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Floor Covering for Maint Room	1996	$ 605	$ 61	10	$ 61	$	$ 363	37
38	Bath Cabinets for Resident	1996	784	39	20	39		235	38
39	Ceiling Tile	1996	496	50	10	50		298	39
40	FRP Board and Supplies for 200	1996	205	14	15	14		81	40
41	Replace Water Lines from Boile	1996	6,000	240	25	240		1,380	41
42	Sanitizing Room/1/2 Down Payment	1996	5,497	550	10	550		3,252	42
43	Install Kemlite in 200 Wing	1996	453	23	20	23		132	43
44	Counter Top/Dining Room	1996	365	18	20	18		103	44
45	Lavatory Water Closet Tank	1996	445	22	20	22		126	45
46	York A/C Unit for 300 Wing	1996	7,100	473	15	473		2,603	46
47	Isolation Valves on Circulation	1996	1,300	130	10	130		704	47
48	Remove & Replace Counter	1996	600	40	15	40		217	48
49	AT & Partner Sys Configuration	1996	8,646	588	6	588		8,226	49
50	Steel Fire Doors	1996	2,857	143	20	143		774	50
51	Air Compressor for Air Handler	1996	511	45	5	45		488	51
52	Install Windows & Screens	1996	420	28	15	28		149	52
53	Water System	1996	4,500	225	20	225		1,181	53
54	Six Birch Doors	1997	590	39	15	39		190	54
55	Amplifier-Intercom	1997	618	62	10	62		293	55
56	12000 BTU's Goodman Air Conditioner	1997	378	76	5	76		352	56
57	Green Louvered Shutters	1997	475	47	10	47		222	57
58	Install New Booster Heater	1997	1,286	129	10	129		590	58
59	Replaced Motor Coupling	1997	1,559	156	10	156		715	59
60	Reconfigured Water Heat Loop	1997	1,800	180	10	180		825	60
61	18 Rooms/Closet Doors/Complet	1997	6,320	421	15	421		1,896	61
62	Outdoor Home Sign	1997	1,000	67	15	67		300	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		**$ 1,872,108**	**$ 68,911**		**$ 68,911**	**$**	**$ 1,360,367**	70

****Improvement type must be detailed in order for the cost report to be considered complete.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,872,108	$ 68,911		$ 68,911	$	$ 1,360,367	1
2	36" Door Frame Guards/Contact	1997	1127	75	15	75		344	2
3	Outdoor Nursing Home Sign	1997	2000	200	10	200		883	3
4	Remodel Bath/Clean & Soiled	1997	33471	1339	25	1339		6471	4
5	Plumbing-Remodel 100 Wing	1997	504	25	20	25		122	5
6	Cabinets	1998	858	57	15	57		214	6
7	Counter Tops	1998	2326	155	15	155		581	7
8	Photo Electric Smoke Detector	1998	420	42	10	42		151	8
9	Lavatory Faucet With Pop Up	1998	362	17	20	17		66	9
10	Plastering Walls	1998	2500	500	5	500		1791	10
11	Labor Material for Wallpaper	1998	3966	397	10	397		1388	11
12	Wallpaper & Border-Dining Room	1998	1529	306	5	306		1070	12
13	Wallpaper & Border-Dining Room	1998	2925	585	5	585		2047	13
14	Material for Wall and Painting	1998	6125	1225	5	1225		4186	14
15	Toilet & Tank	1998	373	37	10	37		127	15
16	Dining Room and Doors Korogard	1998	5925	395	15	395		1349	16
17	Nurses Station	1998	6401	427	15	427		1387	17
18	Wallcovering	1998	5209	1042	5	1042		3385	18
19	Carpet 450 Sq. Yards	1998	10076	2015	5	2015		6718	19
20	Material and Labor to Cable	1998	6033	302	20	302		1006	20
21	Staff Entrance Hall Flooring	1998	1151	230	5	230		710	21
22	Plumbing Repair	1999	2644	264	10	264		793	22
23	Carpet	1999	3750	776	5	776		2328	23
24	Door on 300 Wing	1999	600	40	15	40		120	24
25	Grease Trap	1999	626	62	10	62		188	25
26	Lavatory Faucets	1999	732	37	20	37		107	26
27	Entrance Door on 300 Wing	1999	600	40	15	40		110	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,974,341	$ 79,501		$ 79,501	$	$ 1,398,009	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,974,341	$ 79,501		$ 79,501	$	$ 1,398,009	1
2	Pulled Stool Flange	1999	443	44	10	44		122	2
3	Boiler	1999	693	69	10	69		187	3
4	Gutters Replacement	1999	8,260	826	10	826		2,134	4
5	Rebuilt Corner/Overh. Porch	1999	560	55	10	55		140	5
6	Faucets	1999	1,069	54	20	54		134	6
7	Toilet Tanks	1999	1,628	81	20	81		204	7
8	Water Heater	2000	4,981	498	10	498		955	8
9	Flooring	2000	1,338	268	5	268		379	9
10	AM Standard Faucets	2000	953	48	20	48		69	10
11	Generator Repair	2000	966	97	10	97		129	11
12	Vinyl Floor Finish-Resident Room	2000	7,427	743	10	743		801	12
13	Vinyl Flooring	2001	477	48	10	48		48	13
14	Lockset	2001	1,314	88	15	88		88	14
15	Door Locks	2001	1,825	122	15	122		122	15
16	Toilet	2001	353	15	20	15		15	16
17	Fire Alarm Panel	2001	671	41	15	41		41	17
18	Carpet for Wing Halls	2001	13,485	2,248	5	2,248		2,248	18
19	Carpet for Chapel & Hallway	2001	5,820	872	5	872		873	19
20	Toilets	2001	353	15	20	15		15	20
21	Air Conditioner	2001	708	94	5	94		94	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,027,665	$ 85,827		$ 85,827	$	$ 1,406,807	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,027,665	$ 85,827		$ 85,827	$	$ 1,406,807	1
2	AC for Beauty Shop	2001	329	44	5	44		44	2
3	Ceiling for Dining Room		1,394	23	15	23		23	3
4	Wall Unit, Panels, Priv Screen		967	26	15	26		26	4
5	Corner Guards-Resident Room	2001	162	1	10	1		1	5
6	Doors-Resident Room	2001	1,770	10	15	10		10	6
7	Duct Work-Resident Room		2,139	9	20	9		9	7
8	Interior Partitions-Resid RM		844	5	15	5		5	8
9	Paint-Resident Room Remodel		181	3	5	3		3	9
10	Corner Guards-Resident Room	2001	558	5	10	5		5	10
11	Wallpaper-Resident Room Remode	2001	6,694	112	5	112		112	11
12	CIP - Building - Nursing	2001	143,372						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,186,075	$ 86,065		$ 86,065	$	$ 1,407,045	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,186,075	$ 86,065		$ 86,065	$	$ 1,407,045	1
2	Land Improvements	1967	1,223	-	15	-		1,223	2
3		1975	3,363	-	15	-		3,363	3
4		1978	2,854	-	15	-		2,854	4
5		1979	2,940	-	15	-		2,940	5
6		1981	2,147	-	10	-		2,147	6
7		1982	2,492	-	10	-		2,492	7
8		1983	1,250	-	10	-		1,250	8
9		1990	1,418		10			1,418	9
10		1991	3,967	220	varies	220		3,378	10
11		1992	7,076	620	varies	620		5,746	11
12		1993	427	43	10	43		364	12
13		1994	1,049	70	15	70		536	13
14		1995	5,652	415	varies	415		4,199	14
15	Gazebo & Preparation	1996	3,234	162	20	162		916	15
16	Remove Existing Payment/Comple	1997	7,844	392	20	392		1,732	16
17	Seal Coat Front Parking Lot	1997	2,500	250	10	250		1,104	17
18	Mulch Edging Fabric Weed	1998	583	116	5	116		417	18
19	Edging Pipe Drain Elbow	1998	1,061	106	10	106		381	19
20	Gutter Screen Retaining Wall	1998	902	90	10	90		308	20
21	Perennial/Planting/Landscaping	1999	1,727	155	10	155		328	21
22	Landscaping	2000	1,094	109	10	109		155	22
23	Parking Lot Overlay/Seal	2001	22,000	367	20	367		367	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,262,878	$ 89,180		$ 89,180	$	$ 1,444,663	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 430,225	$ 41,102	$ 41,102	$		$ 220,371	71
72	Current Year Purchases	52,434	3,314	3,314			541	72
73	Fully Depreciated Assets	224,117					224,117	73
74								74
75	TOTALS	$ 706,776	$ 44,416	$ 44,416	$		$ 445,029	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Van	1992	$ 35,985	$	$	$		$ 35,985	76
77	Resident Care	86 Chevy Caprice Wagon	1993	4,553					4,553	77
78	Resident Care	88 Cadillac Brougham	2000	3,510	878	878			1,170	78
79										79
80	TOTALS			$ 44,048	$ 878	$ 878	$		$ 41,708	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,028,702	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 134,474	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 134,474	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,931,400	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments Unit 40	$	$	$	86
87	Building	67,443	2,197	43,669	87
88	FFE	9,826	610	8,519	88
89					89
90					90
91	TOTALS	$ 77,269	$ 2,807	$ 52,188	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 3,668 Description: computer equip lease, air fluid thpy bed, miscellaneous
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$ 445	$ 2,515	$	$ 2,960
2	Books and Supplies		40	280		320
3	Classroom Wages	(a)	449	3,303		3,752
4	Clinical Wages	(b)		1,781		1,781
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests		50	300		350
9	TOTALS		$ 984	$ 8,179	$	$ 9,163
10	SUM OF line 9, col. 1 and 2	(e)	$ 9,163			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	10

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$	249	$ 11,495	$	249	$ 11,495	1
2	Licensed Speech and Language Development Therapist		hrs		126	7,184		126	7,184	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		382	17,628		382	17,628	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Restorative/Program				96	720		96	720	13
14	TOTAL			$	853	$ 37,027	$	853	$ 37,027	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROPHETS RIVERVIEW **#** 0012955 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 82,429	$	1
2	Cash-Patient Deposits	5,050		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12991-4)	338,717		3
4	Supply Inventory (priced at COST)	20,912		4
5	Short-Term Investments	924,961		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,372,069	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	15,000		13
14	Buildings, at Historical Cost	2,253,519		14
15	Leasehold Improvements, at Historical Cost	76,803		15
16	Equipment, at Historical Cost	760,650		16
17	Accumulated Depreciation (book methods)	(1,983,587)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	55,829		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Asset Mngmnt Purch	(576)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,177,638	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,549,707	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 101,130	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	163,620		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,256		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Dep - Apt	800		36
37	Group Ins-Emp Portion/Garnishmnts	1,148		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 388,954	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Rounding	1		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 388,955	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,160,752	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,549,707	$	48

***(See instructions.)**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,150,424	1
2	Restatements (describe):		2
3	**Net Income - Unit 40 Apartments**	9,592	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,160,016	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	25,333	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Dnr Rst Prop/Oper Gift Cash**	1,106	15
16	Other (describe) **Intra-co N/A-CO**	(25,703)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 736	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,160,752	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,527,468	1
2	Discounts and Allowances for all Levels	(237,114)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,290,354	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	8,770	5
6	Therapy	140,810	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 149,580	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	608	12
13	Barber and Beauty Care	3,081	13
14	Non-Patient Meals	11,846	14
15	Telephone, Television and Radio	1	15
16	Rental of Facility Space		16
17	Sale of Drugs	77,577	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,154	19
20	Radiology and X-Ray	1,727	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 101,994	23
	D. Non-Operating Revenue		
24	Contributions	18,076	24
25	Interest and Other Investment Income***	(17,628)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 448	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Nrsg & Medical Supplies	40,267	28
28a	Schedule Attchd	19,261	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 59,528	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,601,904	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	609,090	31
32	Health Care	1,209,617	32
33	General Administration	574,659	33
	B. Capital Expense		
34	Ownership	139,120	34
	C. Ancillary Expense		
35	Special Cost Centers	5,775	35
36	Provider Participation Fee	38,325	36
	D. Other Expenses (specify):		
37			37
38			38
39	Rounding	(15)	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,576,571	40
41	**Income before Income Taxes (line 30 minus line 40)****	25,333	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 25,333	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,965	2,214	$ 44,300	$ 20.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,781	9,242	161,591	17.48	3
4	Licensed Practical Nurses	11,550	12,754	194,680	15.26	4
5	Nurse Aides & Orderlies	49,781	54,184	497,463	9.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	447	765	7,126	9.32	7
8	Rehab/Therapy Aides	2,736	3,089	30,377	9.83	8
9	Activity Director	1,799	2,017	22,141	10.98	9
10	Activity Assistants	5,450	6,209	46,994	7.57	10
11	Social Service Workers	1,940	2,031	27,123	13.35	11
12	Dietician					12
13	Food Service Supervisor	1,824	2,069	23,572	11.39	13
14	Head Cook	6,114	6,800	65,370	9.61	14
15	Cook Helpers/Assistants	9,504	11,184	85,289	7.63	15
16	Dishwashers					16
17	Maintenance Workers	5,128	5,449	51,675	9.48	17
18	Housekeepers	6,601	7,215	57,527	7.97	18
19	Laundry	6,648	7,274	53,147	7.31	19
20	Administrator	1,992	2,103	46,808	22.26	20
21	Assistant Administrator					21
22	Other Administrative	1,893	2,124	32,711	15.40	22
23	Office Manager	1,928	2,155	24,463	11.35	23
24	Clerical	2,985	3,259	27,176	8.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,798	2,040	20,701	10.15	31
32	Other Health C: Driver-Nrsg	285	285	2,011	7.06	32
33	Other(specify) Purch	811	882	10,165	11.52	33
34	TOTAL (lines 1 - 33)	131,960	145,344	$ 1,532,410 *	$ 10.54	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	117	$ 4,179		35
36	Medical Director	24	3,000		36
37	Medical Records Consultant				37
38	Nurse Consultant	2	60		38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	55	1,926		44
45	Social Service Consultant	50	1,933		45
46	Other(specify) Restorative/Program				46
47					47
48					48
49	TOTAL (lines 35 - 48)	248	$ 11,098		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeannette Soleta	Administrator		$ 46,808
Vacation Accural			1,055
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 47,863

B. Administrative - Other

Description	Amount
Admin/Acctg	$ 102,409
TOTAL (agree to Schedule V, line 17, col. 3)	$ 102,409
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
BDO Seidman	Mdcre Cost Report Prep	700
Good Samaritan	Mdcd Cost Report Prep	480
Berens & Tate	Employee Litigation	1,670
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,850

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,387
Unemployment Compensation Insurance	6,278
FICA Taxes	113,163
Employee Health Insurance	93,968
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Taxable Gifts	(2,667)
Salary Reimb	(2,051)
Staff Pension	23,204
Admin/Consultant Savings	1,748
Employee Benefits	8,338
TOTAL (agree to Schedule V, line 22, col.8)	$ 270,368

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,088
Health Care Worker Background Check	1,432
(Indicate # of checks performed)	
Dues Reimb	3,071
Dues - Lobbying - Adm	90
Less: Advertising: Employee Recruit	(3,088)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,593

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 432
In-State Travel	1,056
Seminar Expense	1,541
Rounding	3
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,032

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting - 6 restrooms	10/00	$ 1,913	5	$	$	$ 96	$ 383	$ 383	$ 383	$ 381	$ 287	$
2	Painting - Ceilings	2/01	51	5				11	10	10	10	10	
3	Painting	5/01	9	5				1	2	2	2	2	
4	Painting	6/01	8	5				1	2	2	2	1	
5	Painting	8/01	44	5				7	9	9	9	10	
6	Painting	8/01	31	5				5	6	6	6	8	
7	Painting	8/01	34	5				5	6	6	6	11	
8	Painting	9/01	48	5				5	9	9	9	16	
9	Painting	9/01	10	5				2	2	2	2	2	
10	Painting	9/01	17	5				2	4	4	4	3	
11	Painting	9/01	17	5				2	4	4	4	3	
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,182		$	$	$ 96	$ 424	$ 437	$ 437	$ 435	$ 353	$

Facility Name & ID Number PROPHETS RIVERVIEW # 0012955 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $3071**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,956** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **38,325**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **7,826**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **43%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **HENRY SCHOLTEN & CO** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.